AUTHORIZATION FOR DISCLOSURE OF HIPAA PROTECTED INFORMATION PURSUANT TO 45 CFR 164.508

PURPOSE(S): At the request of the individual, this form is to provide Mobile Bay ABA, LLC d/b/a Mobile Bay ABA Autism Center ("Mobile Bay ABA") with a means to obtain and release disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: continuity of care; personal use; insurance; school; legal; activity participation; discharge/intake; or other reasons.

DISCLOSURE: Voluntary failure to sign the authorization form will result in the non-release of the protected health information.

SECTION I - CLIENT DATA

1. **NAME OF CLIENT** (Last, Middle, First)	2. **DATE OF BIRTH** (MM/DD/YYYY)	3. **NAME OF LEGAL GUARDIAN**
4. **SSN OF CLIENT**	5. **ADDRESS**	6. **TELEPHONE NUMBER**

SECTION II - DISCLOSURE

7. I AUTHORIZE **Mobile Bay ABA** to: ☐ Release ☐ Obtain	8. My information to/from: a. **NAME** of entity to receive or release information	
b. **ADDRESS** (Street, City, State and ZIP Code)	c. **PHONE** (Include Area Code)	d. **FAX** (Include Area Code)

9. **REASON FOR REQUEST/USE OF PROTECTED INFORMATION** (X as applicable)

- ☐ PARTICIPATION IN ACTIVITY
- ☐ PERSONAL USE
- ☐ INSURANCE/MEDICAID
- ☐ CONTINUITY OF CARE
- ☐ SCHOOL/WORK
- ☐ LEGAL/STATE COMPLIANCE
- ☐ DISCHARGE/INTAKE
- ☐ OTHER (Specify) ____

10. **INFORMATION TO BE RELEASED** (X as applicable)

- ☐ ALL INFORMATION IN PARTICIPANT CHART
- ☐ MEDICAL INFORMATION (including medications)
- ☐ PSYCHIATRIC AND PSYCHOLOGICAL INFORMATION (including medications)
- ☐ ISP/IP ONLY
- ☐ BEHAVIOR PLAN AND DATA
- ☐ PHOTOGRAPHS
- ☐ RECORDS (other than medical, psychiatric, psychological or behavioral)
- ☐ OTHER (Specify) ____

11. **AUTHORIZATION START DATE** (DD/MM/YYYY)	12. **AUTHORIZATION END DATE** (expires no later than one year from start date)

SECTION III - RELEASE AUTHORIZATION

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to Mobile Bay ABA. A section is provided at the bottom of this form for the purpose of revoking consent. I am aware that if I later revoke this authorization, the entity or person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.

d. I understand that I am under no obligation to sign this form and that Mobile Bay ABA does not condition program eligibility or participation on failure to obtain this authorization.

I have had the opportunity to review and understand the contents of this form, and hereby request and authorize Mobile Bay ABA and the named individual/organization to release or obtain, as indicated above, the information described above.

10. **SIGNATURE OF PARTICIPANT/LEGAL GUARDIAN**	11. **RELATIONSHIP** (If applicable)	12. **DATE** (DD/MM/YYYY)

SECTION IV - AUTHORIZATION REVOCATION

I HEREBY REVOKE MY PREVIOUS CONSENT. I NO LONGER AUTHORIZE THE NAMED PROVIDER/ INDIVIDUAL/ORGANIZATION/Mobile Bay ABA TO RELEASE THE INFORMATION DESCRIBED ABOVE TO THE NAMED INDIVIDUAL/ORGANIZATION INDICATED.

I understand that the entity or person(s) I named above will have already used and/or disclosed my protected information on the basis of my previous authorization. I further understand that the above authorization automatically expires one year from the start date or on the end date specified if not revoked earlier by signing below.

11. **SIGNATURE OF PARTICIPANT/LEGAL GUARDIAN**	12. **RELATIONSHIP** (If applicable)	13. **DATE** (DD/MM/YYYY)